

# Key Factors to Facilitate Locally Driven Family Planning Programming: A Qualitative Analysis of Urban Stakeholder Perspectives in Africa and Asia

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## Research

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# Abstract

## Background

There has been greater recognition of the importance of country ownership in global health and development. However, operationalising country ownership to ensure the scale up and sustainability of proven interventions remains elusive at best. To address this challenge, we undertook a thematic analysis of interviews collected from representatives of local governments, public health systems, and communities in poor urban areas of East Africa, Francophone West Africa, India, and Nigeria, supported by The Challenge Initiative, aiming to rapidly and sustainably scale up evidence-based reproductive health and family planning solutions.

## Methods

The main objective of this study was to explore critical elements needed for implementing and scaling evidence-based family planning interventions. The research team conducted interviews and collected 96 stories using the Most Significant Change (MSC) technique between July 2018 and September 2019, and coded and analyzed the stories. Most frequently used codes were identified and grouped into emerging themes.

## Results

Five key themes emerged: (1) strengthening local capacity and improving broader health systems, (2) shifting mindsets of government and community toward local ownership, (3) institutionalizing the interventions within existing government structures, (4) improving data demand and use for better planning of health services, and (5) enhancing coordination of partners.

## Conclusion

While some themes feature more prominently in a particular region than others, taken together they represent what stakeholders perceive to be essential elements for scaling up locally-driven health programmes in urban areas in Africa and Asia.

## Background

Scaling up a programme for widespread adoption remains a challenge in global health, despite the existence of effective and innovative products, practices, and interventions. On average, it takes nine years for research evidence to be implemented into practice [1]. Accelerating scale up of a hypothetical 20-year global health programme by just 1 year can reach 10% more people, resulting in a significant impact on lives saved [2].

As a result, scaling up proven global health interventions requires donors, programme implementers, and stakeholders to rethink how programmes are funded, structured, and implemented. Traditionally, global

health programming has been top-down: “It has involved interventions in the name of others though frequently without their explicit sanction, control, or even participation” [3]. Since the 2005 Paris Declaration on Aid Effectiveness, there has been greater recognition of the importance of country ownership in development. However, operationalising country ownership to ensure the scale up of proven global health interventions that lead to sustained impacts remains elusive at best.

To address this issue, The Challenge Initiative (TCI) aims to rapidly and sustainably scale up evidence-based family planning and adolescent and youth sexual and reproductive health (AYSRH) interventions, in genuine partnership with local governments across poor urban areas through its ‘business unusual’ model. TCI’s business unusual model is guided by six principles: (1) *Demand-driven*: local governments self-select and bring their own finances and ideas for addressing their family planning issues to the table; (2) *Local ownership and system readiness*: local governments must be ready, willing, and able to address their issues by leading implementation of evidence-based interventions; (3) *Right-fitting interventions*: TCI works with local governments to adapt evidence-based interventions to local conditions and context; (4) *Coaching support*: TCI provides support to local governments to design, manage, and implement programmes themselves; (5) *Leveraging and activating existing structures and systems*: TCI works within existing government- and community-led systems to harmonize strategies, plans, funding, and technical assistance and avoid duplication, waste, and missed opportunities; (6) *Using near- to real-time data*: TCI stresses the importance of adaptive management techniques by using data for problem solving and better decision-making.

TCI began implementation in September 2017 in three cities of East Africa and has since scaled, as of this writing, to 94 cities in East Africa (Kenya, Tanzania, and Uganda), Francophone West Africa (Benin, Burkina Faso, Côte d’Ivoire, Niger, and Senegal), India, and Nigeria. This article aims to investigate which of the guiding principles of TCI’s business unusual model are most frequently identified by country-based stakeholders in low- and middle-income urban settings as significant game-changers in the implementation and scale up of evidence-based family planning and AYSRH interventions. This analysis disrupts the current paradigm that is represented in the scale-up literature by elevating the voices of representatives of local governments, public health systems, and community stakeholders, rather than relying on interviews with “thought leaders” or public health experts, to define the critical elements needed for effective implementation and scale up of proven practices [4, 5].

## Methods

TCI uses the Most Significant Change (MSC) technique as a qualitative monitoring method in order to gain a fuller understanding of not just *what* the project is accomplishing but also *how*. For this analysis, four members of the TCI research team conducted secondary analysis of all of the MSC stories collected in the first year of implementation of the method.

### *Data collection*

The research team developed a semi-structured interview and focus group discussion guide informed by the MSC technique [6]. Data collectors who also served as TCI coaches interviewed stakeholders through purposive sampling. The stakeholders interviewed represented those adapting and implementing evidence-based family planning interventions and those responsible for the oversight and financing of family planning programmes at the city, municipality, county, or state level, depending on the location's particularities. Some family planning clients and TCI project staff were also interviewed.

For this analysis, we included MSC stories collected between July 2018 and September 2019. The specific timeframe for data collection differed by region, varying from 6 months in Francophone West Africa to 15 months in India, based on when training on the MSC method occurred. In general, this timing corresponds to the second year of implementation of TCI-supported evidence-based interventions. In total, 118 MSC stories were collected during this time period. Of these, 96 MSC stories met inclusion criteria: they included information on the situation prior to TCI's involvement, the change as a result of TCI's involvement, and the significance of the change.

### ***Data management and analysis***

The interview teams either audio-recorded and transcribed or took detailed notes of the interviews and focus group discussions using an interview guide. Interview transcripts were translated into English when another language was originally used (e.g., Hindi or French).

For this analysis, the research team first transferred all of the stories into a Google Sheet to track and organise the transcripts by country/region and other related characteristics, such as job title and sex of interviewees. Then, each of the four researchers coded six transcripts manually to become familiar with the content and develop an initial set of codes. The team coded phrases and sections within each story to summarise the data, electing to use process codes; process codes employ gerunds (-ing words) to draw out observable and conceptual action in the data [7]. This form of coding seemed particularly relevant in this context because the intention was to extract the actions and consequences of programme planning, implementation, and scale up. The team generated the codes inductively—that is, the codes were created and iterated based on the data rather than predefining the codes a priori—and maintained a codebook of all the codes, along with the definitions. From the small sample of test stories, the research team identified initial codes that were iterated throughout the analysis of the 96 stories. Two of the researchers then coded all of the stories in Atlas.ti software (version 8.4.4) to organise the data under codes. To achieve intercoder reliability, the two members of the research team working in Atlas.ti each coded 20% of the stories separately and reviewed each other's work to come to consensus before dividing the rest of the stories between themselves.

Ultimately the analysis included 55 unique codes. The research team identified the most frequently used codes and grouped them into emerging themes.

## **Findings**

Of the 96 stories that were included in the analysis, nearly half (49%) were from the Nigeria hub, while East Africa and India each contributed about one-quarter of the stories, and Francophone West Africa contributed four stories (Table 1). The disproportionate collection of stories was attributable to the timing of training and delays in rolling out the MSC method due to staff turnover in Francophone West Africa. Interviewees represented a range of roles in the health system, from government stakeholders (27%) and service providers (20%) to TCI managers (12%) and community leaders (9%). Twelve percent of the stories were from the client’s perspective. The interviewees were relatively evenly split between women and men, with women making up 53% of interviewees. Some stories were compiled through group interviews and thus included more than one interviewee.

**TABLE 1. Distribution of MSC Stories by Characteristic (N=96)**

<b>Regional Hub (where stories originated)</b>	<b>No. (%)</b>
Nigeria	47 (49)
East Africa	24 (25)
India	21 (22)
Francophone West Africa	4 (4)
<b>Role of interviewee in the health system</b>	
Government official	26 (27)
Service provider	19 (20)
Health client	12 (12)
TCI state or city manager	12 (12)
Community leader	9 (9)
Community health workers (CHWs)	7 (7)
Health educator/social mobilizer <sup>a</sup>	5 (5)
Implementing partner	3 (3)
HMIS/M&E officer	3 (3)
Other facility staff	2 (2)
<b>Sex of interviewee</b>	
Female	51 (53)
Male	38 (40)
Multiple storytellers	7 (7)

*Abbreviations: HMIS, health management information system; M&E, monitoring and evaluation*

*<sup>a</sup> Note: Health educators are government employees, but they are grouped with non-governmental social mobilizers since both health educators and social mobilizers provide information/counselling to clients, but not services.*

From this analysis, five key themes emerged as aspects of TCI's business unusual model that facilitate implementation and lead to positive changes in scale up and sustainability of family planning programmes, according to TCI's stakeholders: (1) strengthening local capacity, (2) shifting mindsets toward local ownership, (3) improving government health systems, (4) improving data demand and use, and (5) enhancing coordination of partners. In general, the codes applied to the MSC stories in this analysis appeared across the regional hubs, but some codes featured more prominently in certain regions. We explore each of these themes and highlight notable regional variations in the sections below.

### **1. *Strengthening local capacity***

The most frequently mentioned themes in the MSC stories related to capacity strengthening, with about one-third of all stories highlighting various elements linked to capacity strengthening. This trend was more prominent in India, where many of its stories described changes in local capacity. Specifically, those stories pointed to the value of embedding and aligning TCI tools and evidence-based interventions within existing city structures and processes to facilitate their adoption and to help government staff, especially at the facility level, perform their jobs better. For example, a service provider in Uttar Pradesh, India, explained:

This [data reporting tool] made it possible to review the health center's family planning data during monthly government meetings ... and take corrective actions including arranging human resources and family planning supplies. Having accurate data in a simple format that was being reviewed regularly encouraged better performance and motivated the facility staff and community health workers to give their best.

Many stories described various coaching, mentoring, and training opportunities that stakeholders received from TCI, which focused primarily on city-level implementation of evidence-based family planning interventions. Thematic analysis elucidated the characteristics of TCI's coaching approach that they value most. For example, a government official in Bauchi state, Nigeria, referenced consistent access to coaching support:

TCI ... is different from other projects [in] that the [TCI] office is embedded inside the agency. In fact, they are like staff of the agency, and so collaborating with the staff of the agency in order to provide technical support needed is within the same environment.

Furthermore, TCI stakeholders noted the outcomes of coaching support related to broader health systems functions, such as leadership, management, and coordination. A government official from Dar-es-Salaam, Tanzania, explicitly linked skill building in management, budgeting, and monitoring and evaluation to improved government leadership and service to the community:

We, the government staff, are now involved in planning, budgeting, monitoring, documenting, and evaluation... Right now, planning is done at both facility and municipal levels. Through TCI, there are so many improvements and our activity and budget plans are smart. Most of [the] challenges we used to face have been minimized. The local government knows the community needs and we now have a sense of ownership and we aim at sustaining it.

## ***2. Shifting mindsets toward local ownership***

Another frequently occurring theme across the region was changing mindsets about the important role of local governments and communities in leading family planning programmes. Altogether, about one-third of the stories covered mindset changes, and the stories from East Africa and Nigeria illustrated such outcomes more prominently than the two other regions. For local governments, the mindset shift was linked to increased political and financial commitments. At the community level, the analysis revealed how community stakeholders recognized the essential role they could play in improving the health of their communities. In both cases, the mindset changes were noted as a foundational step to motivating action among local government players and community members to improve access to and use of family planning services.

### *Local government players*

Local government stakeholders often described TCI's approach to locally driven solutions as a novel one that they were unaccustomed to—one that they embraced and that prompted them to take action. For example, a health educator in Rivers state, Nigeria, described how empowering this mindset change was:

We are seeing an NGO coming to say that “you drive the process and we follow.” We are seeing ourselves in the driver's seat and if we don't do it, no one else will! It calls for ownership and participation at the state level, LGA [local government area] level, and community level. That is a very great change.

In Uganda, a service provider celebrated the mindset shift and movement toward increased ownership and accountability among city government, commenting:

Nowadays, our political leaders are interested in knowing how much of the geography money we are spending in family planning.... Before TCI came on board, these leaders were not asking such accountability-related questions.

Several stories described how stakeholders witnessed the impact of TCI's demonstration of its evidence-based approach, “dedicated day for family planning services,” in which trained staff, equipment, supplies,

and commodities were made available on a pre-announced day and time at an urban primary health center. A service provider of Uttar Pradesh, India, declared:

Family planning was the last thing on anyone's mind at our urban primary health center. However, after observing and participating in the special drive [for family planning services] in 2018 facilitated by TCI, I saw people coming in for family planning services. From that day onwards, we are regularly conducting dedicated service day without the support of the TCI team.

These mindset changes also spur local stakeholders' involvement in better understanding and responding to community needs. For example, in Plateau state, Nigeria, a government official shared how one community issue was resolved:

When the deputy governor's wife and governor's wife were commissioning the facilities, we learned that they [the facilities] didn't have water.... We dug a borehole and put a tank in place to pipe the water. I was able to do this with money that the state already had available. We didn't know that water was an issue before TCI. The TCI model gives us an opportunity to enter to see what some of the problems are.

### *Community members*

Many stories, in particular those from Nigeria, described the community as a key contributor to and implementer of TCI's evidence-based interventions. This support or engagement with community structures has not only improved the family planning knowledge of community members but also changed their negative attitudes and perceptions of services and empowered them to take action to further help improve service delivery in their communities. For example, an implementing partner of an NGO visited Bauchi state, Nigeria, to learn from its experience implementing the clinic makeover approach and then used that learning to replicate the approach across Gombe state, a non-TCI supported state in Nigeria. A key lesson learnt that the partner took away from the experience was the profound change that he saw within the community:

The work continued to the next day, which is Sunday ... with a renewed commitment from the community representatives and the staff including the artisans themselves. In fact, you can see clearly from their faces because they have that impression of owning the process, it is their facility, it is their families who are the direct beneficiaries.

Some stories described how TCI's evidence-based interventions targeted key influencers, such as traditional and religious leaders and community members who served as community health workers (CHWs), to become family planning champions. Following an engagement with TCI, a religious leader in Plateau state, Nigeria, explained that he was carrying out a door-to-door campaign among his network to share the importance of family planning and that he was sharing what he learned from TCI with other religious leaders, which sparked a broader mindset change among the Muslim clerics in his area:

There were misconceptions on the part of the Islamic clerics, they normally interpret child birth spacing as controlling population but after our interaction with them using the Islamic Perspective and Sermon notes

on child birth spacing [from TCI], a lot of them have now understood that spacing in between births for the health and well-being of the mother and child is also promoted in the Holy Quran.

In several stories, CHWs from India shared their concerns about counselling on family planning during household visits. After receiving coaching support from TCI, the CHWs reported that their images improved within their communities as women began to seek them out for family planning information and services. A CHW in Odisha, explained:

Since I had never done this before, I thought that the situation is going to be very embarrassing in the field and I may lose my good connection. ... These [coaching sessions] were extremely useful. Now I hold these conversations independently, and rather enjoy doing so because I find that women are making their own decision about contraception.

These mindset changes in the community extended to youth as well. For example, in Benin, a government official highlighted the role of youth in implementation of AYSRH programmes:

The youth in general and young leaders are more and more responsible; as you see them taking part in activities, you can see that they are willing to do their best.

### ***3. Improving government health systems***

Improving government health systems was another frequently captured theme. Stakeholders illustrated various examples of how TCI's evidence-based interventions had been institutionalized, diffused, or scaled across the health system. About half of the stories in India illustrated specific examples related to this theme. For instance, the local government, with coaching support from the TCI team in India, mapped and defined slum catchment areas to better define service needs and allocate resources. All government programmes, including family planning, immunization, and maternal and newborn health, started using the slum maps to plan urban health interventions and reported that the mapping and listing intervention had resulted in the strengthening of the urban health system. Additionally, a number of MSC stories from India highlighted how TCI has helped to streamline government systems to process timely release of incentive payment to CHWs, which has resulted in increased motivation among the workers. A CHW from Madhya Pradesh explained the significance of this change:

Earlier, we were not aware of our incentives or responsibilities.... Once [TCI] intervened, our meetings were formalized with our health center staff every Saturday. Now, we are regularly being updated about our programs and incentives.... We are well-versed about the health worker diary [register] and the processes of voucher filling and submission, which we did not know earlier.

Several MSC stories from Nigeria described how the improved facility infrastructure from clinic makeovers supported delivery of not only family planning services but also primary health care services overall. A stakeholder from Plateau state, Nigeria, explained that the government recognized this and supported replication of the clinic makeover approach in other non-TCI supported health centers.

Analysis of MSC stories also revealed a more effective use of existing public health sector staff. For example, a service provider in Ziguinchor, Senegal, highlighted the impact of universal referral, an evidence-based intervention that TCI coached the government on how to implement, which involves maternal and newborn care staff screening their clients for family planning services:

Through TCI tools, a client may now be identified as needing family planning services. She is systematically given the referral sheet for necessary care and when she comes back, she is identified as having received FP services. This strategy did not exist in the past.

#### ***4. Improving data demand and use***

Many stories, especially the ones from India and East Africa, presented a case about improving data for decision-making. These fell into three categories: (1) how TCI used data as part of its advocacy efforts to motivate and inspire local governments to prioritize family planning interventions; (2) how TCI strengthened the capacity of local stakeholders to collect, analyse, and use data; and (3) how this capacity strengthening in data use ultimately led to a culture of data demand by both local government stakeholders and implementers at the facility level.

##### *Data-informed advocacy*

MSC stories described a number of approaches to foster local ownership and investment and how those approaches were critical for implementation and scale. One approach involved direct advocacy to local governments to add a budget line item for family planning and AYSRH—and to release those funds. These advocacy efforts resulted in local government allocation and release of funds for family planning programmes in general and for AYSRH programmes specifically.

In addition, several stories described how data was used to demonstrate success of the evidence-based approaches, which then spurred systems-level changes. For example, in Uttar Pradesh, India, several stories described how TCI demonstrated the success of a dedicated day for family planning services in 25 demonstration sites over a two-month period. Upon reviewing the data demonstrating primary health centers' capacity to provide quality family planning services, the local government deemed the dedicated family planning day a worthy investment and scaled the approach throughout all urban primary health centers. One government official noted:

When we find out that something [is] good and workable [and] produces results quickly, we take it into the system—which is what we have done in case of the dedicated day for family planning services. This is now part of [the] center's charter and [is] going to sustain forever. The system works, not individuals. So, when something is introduced or added into the system, no one needs to worry about its sustainability.

##### *Data-improved capacity*

Many of the stories referred to the significance of the coaching support that TCI provided to its public sector counterparts in a number of areas, a key area being capacity to collect, interpret, and use data. For

example, a monitoring and evaluation officer of Bauchi state, Nigeria, shared:

My capacity has now been built not only on how to log into the HMIS platform but how to download data, analyze, and compare it to see the differences and improvements. Not only that, my capacity has been strengthened that I collate monthly data from health facilities and conduct data quality assessment and share it with implementing partners. It wasn't like this before the coming of TCI. I feel very confident now.

Similarly, a health educator in Uganda reported improved capacity among all community outreach workers in her district:

The Iganga District Health Team noticed a huge improvement in the capacity [of the community outreach workers] to compile and submit their reports, including those of family planning. Many of the health facilities have now incorporated VHT [volunteer health team] data into the HMIS monthly health facility report and reporting is on time. VHTs are now in position to cross check in the HMIS to ensure their data is incorporated in the health facility report.

### *A culture of data for decision-making*

Several stories highlighted the use of both TCI-generated reporting tools and a government-owned data platform as ways to promote a culture of data use for decision-making. These efforts improved data accuracy and timeliness of health information data, leading to greater government ownership of the evidence-based interventions supported by TCI. For example, a health information focal person in Uganda shared how the integration of data from CHWs into facility registers, which was reported into the data platform, has helped target services more effectively:

Nowadays, health workers are more responsible and health facilities own their data. They ensure completeness of their FP [family planning] data reports so that their efforts are realized. Community health workers have learnt to demand for their data to be displayed at the health facilities. We now discuss our FP data regularly and the service providers are able to identify gaps and strategies to improve performance. We are able to take FP services where they are most needed.

A data assistant in Uganda noted how more accurate facility-level data was used to better target services to the population, leading to improved access to and quality of services:

Most of the facilities are now prioritizing using data for decision-making, which is evidenced by graphs and charts drawn in some FP units supported by TCI. The division has observed a huge improvement in terms of FP service delivery access and quality. Through outreaches—a TCI evidence-based intervention—FP services are taken closer to the urban poor who may not afford transport to the facilities.

## **5. *Enhancing coordination of partners***

The stakeholders' stories, particularly from East Africa and Nigeria, illustrated how enhanced coordination leads to more agile, impactful programming. For example, a government official in Bauchi state, Nigeria,

emphasized how TCI has empowered her to coordinate the various implementing partners:

TCI provided a platform for us to see a reason for all partners to come together under one umbrella so that we could move to make things happen better and quicker with less stress but greater impact.... Now the agency knows and coordinates activities of partners. There is synergy now... every partner has a shared vision.

Several stories touched upon how TCI brought a range of stakeholders together to roll out implementation of evidence-based interventions, resulting in the integration of family planning into other health programmes, such as maternal, newborn, and child health, ultimately meeting women's and families' needs more holistically. A health educator of Rivers state, Nigeria, explained:

We were able to build family planning into our other programs—Maternal Newborn and Child Health Week, for example... We will be having quarterly meetings at the local level to bring different stakeholders together through the help of TCI.... We are able to expand more.

Some stories illustrated how the coordination effort went beyond direct partners and donors and reached out to the local government units. In Senegal, a government official described how TCI activated coordination across three of the five municipalities comprising the region:

With TCI, our three city councils have pooled their funds to deliver FP and AYSRH services in some geographies. We will respond collectively... and this practice is unusual. All of the activities in the action plan are implemented at the same time in Bignona, Oussouye, and Ziguinchor.

Other stories pointed to the significance of enhanced coordination between the public health system and the private sector for improved family planning service delivery as a result of TCI's capacity strengthening. A service provider in Uganda said:

There is better coordination with private health facilities and we have [an] improved referral system. So, a client who does not want to come to the public health facility will still get the family planning service at the private health facilities. Before this, we were only concentrating on the public facilities. We have strengthened the capacity of the midwives providing family planning in the private sector.

This coordination also extended to improving linkages between the community and service delivery system by activating community structures. For example, strengthening women's groups was an evidence-based practice in India that aimed to strengthen community accountability and facilitate access to family planning services among the urban poor. A government official conducted a visit to a women's group and noted his excitement at seeing the mother's group successfully activated:

I was enthralled to hear this amazing true story of these women champions. If these women groups were to work as a true connection between the community aspirations and health service delivery, then the day will not be far when every citizen of the country will get quality health care services provided for them by the government.

## Discussion

This analysis of nearly 100 MSC interviews elevates five key factors for ensuring locally driven family planning programmes from the perspective of local government officials, service providers, community leaders, and other health systems stakeholders from 10 countries with diverse socio-political contexts and health systems of varying maturity levels. First, *capacity strengthening* of local officials to implement evidence-based interventions as well as broader health systems functions through coaching creates a positive feedback loop, whereby cities are exposed to the tangible benefits of their efforts. The majority of MSC interviews reported on how TCI's coaching support has led to individual and organizational capacity strengthening. Alongside this capacity, *mindsets* of both local government officials and of community members shift toward local ownership, empowering and motivating them to contribute more of their own resources to expand access to and use of health services. The demand-driven nature of TCI's partnership with cities is reinforced and strengthened through coaching and changes in mindsets toward local ownership. Third, institutionalization of evidence-based interventions within existing government structures and a focus on *improving government health systems* leads to diffusion of the interventions beyond the geographic areas that receive the initial investment. Leveraging and activating existing structures and systems, instead of creating parallel structures, not only strengthens local ownership but also strengthens capacity within the system. This is evidenced by TCI's commitment to using the government-owned HMIS for monitoring and evaluating the impact of the evidence-based interventions. In addition, engendering a *culture for data demand and use* helps improve the accuracy and timeliness of data, leading to improved planning and targeting of family planning services to populations in need. Finally, improved *partner coordination* further highlights the importance of leveraging existing systems and structures, which leads to more agile, impactful programming. For example, in Nigeria, this is achieved through state-wide integrated family planning workplans developed by the state government with support from TCI to bring together all implementing partners to transparently share their individual project objectives and plans. In addition, in most poor urban cities in low- and middle-income countries (LMICs), it is critical that the public and private sectors work in partnership to meet the health needs of the ever-growing urban population. Although private sector partnerships were not frequently reported in our collection of stories, this is an area that TCI is actively working on with local governments and expect to see as an emerging theme in future MSC stories.

These five themes align with all six of TCI's business unusual guiding principles. However, the demand-driven and right-fitting principles did not come out as frequently as the other principles in the MSC stories. This may be for two reasons. First, both of these principles are built into the process of engagement with TCI in which local governments decide whether to complete an expression of interest to join the TCI partnership and select which evidence-based interventions meet the needs of their specific context. As a result, the interviewees may not view these aspects of the model as part of the implementation approach but pre-implementation processes. Second, a number of the principles are interrelated. For example, demand-driven and local ownership go hand-in-hand. However, interviewees reported more frequently about the significance of the mindset shifts that they experienced toward local ownership in leading and managing their family planning programmes and implementing the evidence-based interventions than

the demand-driven aspect of the model in which they commit their own financial resources to implementation. The analysis also revealed that the stakeholders view coaching local governments to align and adapt evidence-based interventions within existing government systems and structures as a significant factor, which is related to the process of right-fitting or adaptation itself.

One important aspect that emerged in our analysis that could be emphasized more in TCI's guiding principles is *community ownership* in addition to local government ownership. Community ownership and mobilization have been identified in a recent systematic review as crucial facilitators of intervention sustainability [4]. The current global challenges of pandemics and outbreaks also signal that local government and community ownership is required in scaling safety measures for preventing further spread of deadly viruses. There is no one shared definition or construct related to community ownership. However, it has been presented as on the path to effective and sustainable health interventions [8]. Communities ensure government accountability and extend the limited resources of government. Interviewees emphasized community resources as an important input when strategizing to maximize contributions and impact. Community members also served as decision-makers and implementers of the evidence-based interventions, and community ownership was celebrated alongside local government ownership in several interviews. This finding is supported in the literature related to barriers to scaling up, which include lack of engagement of local implementers and of the adopting community [9]. Subsequent research should explore whether or not perceptions of community ownership change over time, especially as engagement with TCI gradually ends.

Our results add to the body of the literature in the scale-up and sustainability fields by providing perspectives from local stakeholders themselves, rather than from public health "experts" or "thought leaders," on important facilitating factors. These stakeholders highlighted coaching to strengthen capacity, alignment of interventions, tools, and approaches with the existing system, the use of data for decision-making, and coordination of partners as significant elements needed to facilitate local ownership and implementation of evidence-based interventions, with the ultimate goal of scale up and sustainability. These themes are applicable to the implementation of evidence-based interventions beyond family planning and are also supported by existing literature that has identified key facilitating factors for scale-up to include strong leadership and governance, active engagement of a range of implementers and of the community, and simple interventions proven to be effective and tailored to the local context with recognizable benefit to the local population [10, 11, 12, 13]. These are also necessary factors to support the *sustainability* of evidence-based interventions and public health programmes beyond the initial funding period. In the sustainability literature, these factors include programme design elements such as stakeholder involvement and working with existing resources; organizational characteristics such as favorable organizational culture, strong leadership, and sound infrastructure; and environmental features such as community engagement and ownership [14, 15, 16].

We believe the cornerstone of successful implementation and scale efforts is coaching of local health systems actors to strengthen their capacity to design, implement, manage, and continually monitor and adapt their own health programmes to changing conditions. Shifting mindsets and fostering local

ownership starts with building and cultivating leadership, which Brownson et al. (2018) noted as the most important aspects of capacity. TCI aims to strengthen local government leadership at the systems, organizational, and individual levels by systematically embedding coaching within existing local structures. Initially, our coaching approach focused primarily on strengthening capacity to scale up specific evidence-based interventions. We quickly learned that technical know-how is necessary but not sufficient to ensure sustained scale and impact of quality family planning and AYSRH programmes. Our coaching support evolved to include strengthening leadership skills, programme management, coordination, planning, budgeting, and use of data to inform decisions—skills that will help ensure sustainability of implementation beyond TCI's support. Because our coaching approach was designed to be flexible to meet the needs of local health systems, the specific details on how coaching is implemented vary between countries and regions. A study is currently being carried out to document the “how” of our coaching approach and to assess the specific outcomes that are associated with coaching.

## Limitations

There are some limitations with this analysis that should be noted. Since the data collectors come into regular contact with the interviewees through coaching sessions, there may be a courtesy bias in which the interviewees report mainly on positive changes and/or the data collectors select to interview individuals who have had positive experiences. In addition, the five countries in which TCI is implemented in Francophone West Africa are underrepresented in this analysis due to staffing turnover and, therefore, challenges in providing coaching support to local governments and limited ability to collect interviews. Finally, this analysis represents the early experience of implementing evidence-based family planning and AYSRH interventions by TCI stakeholders (within the first two years of implementation). At a later point when TCI begins to withdraw its coaching support, the findings may change.

## Conclusion

When local leaders are in the driver's seat of their health programmes, evidence-based interventions are able to reach more people and have greater impact, especially when communities themselves are empowered and involved in planning and implementation. The analysis of nearly 100 MSC interviews with local implementers and stakeholders of four LMIC regions highlights five key themes as important factors in the implementation and scale-up of locally driven health programmes: (1) strengthening local capacity to implement evidence-based interventions and improve broader health systems, (2) shifting mindsets of government and community toward prioritizing family planning programmes and local ownership, (3) institutionalizing the interventions within existing government structures, (4) improving data demand and use for better planning and targeting of health services, and (5) enhancing coordination of partners. While some themes feature more prominently in a particular region than others, taken together they represent what stakeholders perceive to be essential elements for scaling up locally-driven health programmes in urban areas of LMICs.

This analysis is timely as external funding from traditional donors is decreasing at the same time that their expectations to make the most of their funding is rising. Governments in LMICs are being called upon to increase domestic spending and co-finance health programmes while new mechanisms, such as the Global Financing Facility, are being introduced, driving a shift from grants toward mixed funding.<sup>38</sup> In this environment, the findings from this analysis can influence how other programmes and innovations are designed for implementation and scale.

## Declarations

Ethics approval and consent to participate: The Institutional Review Board of Johns Hopkins University approved the study procedures. Written consent was provided by all study participants.

Consent for publication: N/A

Availability of data and materials: N/A

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